Patient Care Review

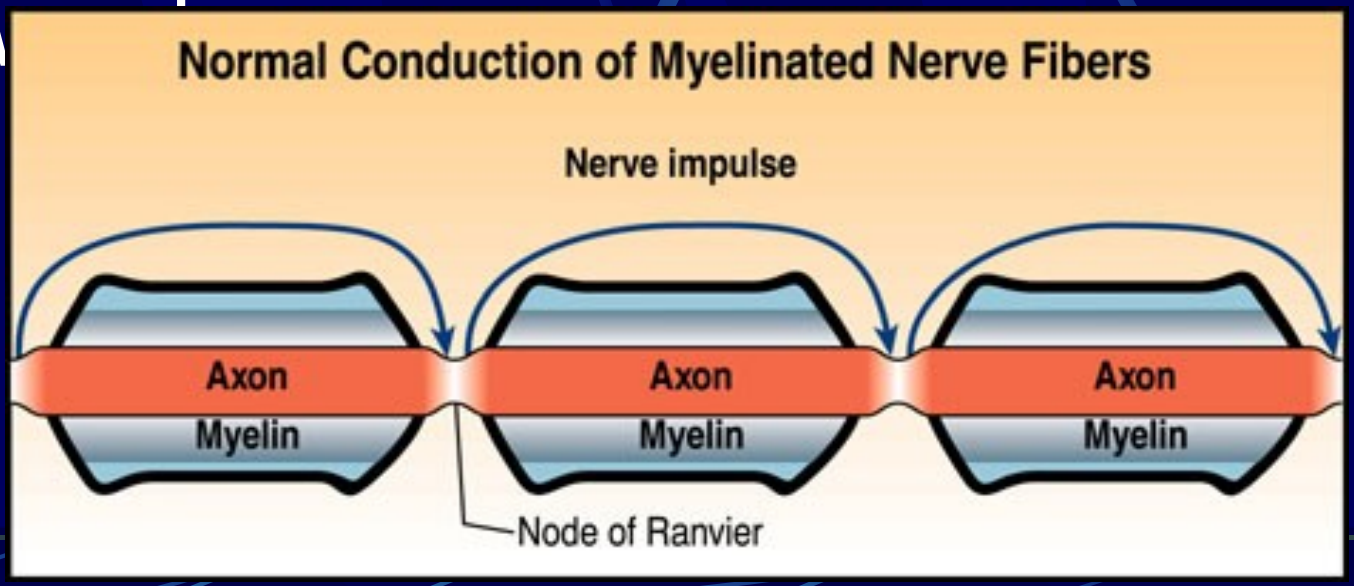
2LT Tamrin Olson
MNT Basic Rotation
CPT Kaefer

Patient: KES

- 28 YOWF
- AD USN – stationed in Japan
- Date of Admission – 29 Aug 00
- Chief Complaint: Progressive Weakness
- Dx: Chinese Paralysis Syndrome
  (~Guillian-Barre Syndrome)

Guillain-Barre Syndrome

- Body's immune system attacks part of the peripheral nervous system as seen by motor



Guillain-Barre Syndrome

- Sudden unexpected onset of symptoms
- 1st signs – varying degrees of weakness/tingling sensations in the legs
- Many times the weakness spreads to arms and upper body
- Symptoms can increase in intensity until muscles cannot be used

Guillain-Barre Syndrome

- No known treatment
- High dose immunoglobulin therapy
- Plasma Exchange
- Corticosteroids ????

Guillain-Barre Syndrome

- Etiology unknown–viral/bacteria infection???
- Prognosis: usually a considerable improvement over a period of months
- ~30% of adults have residual weakness at 3 yrs
- ~3-10% have a relapse
- Main cause of death: pneumonia or adult respiratory distress syndrome

KES

- PMH: None
- PSH: L elbow surgery – 98
  R wrist surgery - 93

KES-Progression

- Tingling in R hand – July 1999
- More difficulty putting hair up – Dec 1999
- Weakness progressed to involve RUE – point of flaccidity
- L shoulder strength decreased – Jul 2000
- Descending weakness starting @ hip

KES-Progression (Aug 2000)

- LLE becoming weaker
- Ambulation is becoming difficult
- Throat spasms
- “Jumpy” legs when preparing to sleep
- No dysphagia,dysarthria, visual changes, sensory changes,or difficulty speaking

KES-Progression (Recent)

- Progressive dysmobility
- SOB (O2 levels monitored)
- Must be positioned to eat or sometimes spoon fed
- Experiencing anxiety

Current Treatment

- IVIG: 7200 mg q wk (Mon) (5 wk regimen)
- PT & OT

Reasons for Dx

- Campylobacter in Japan?????
- Anthrax?????
- Mystery?????
- Multiple etiologies investigated (heavy metals, toxic screen hepatitis, HIV, Lyme, B12/Folate, spinal tap)

Nutrition History

- Diet at Home: Regular
- Admission/Current Diet: Regular
- Good Appetite
- Well nourished

Physical Exam

- Ht: 67”
- Wt: 154 lbs (Admission)
- DBW: 145-157 MHWT
- 100% of DBW and UBW
- 93% of admission wt (11/8)
- Decreased tone in all extremities; UE>LE

Supplements

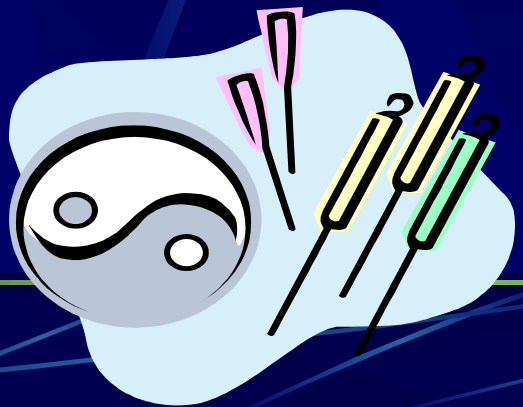
	RDA	UL	Dosage	MVI	Sx
B6	1.3 ug	100 ug	100 mg QD	0.5 mg	Nerve/Liver
Niacin	14 mg	35 mg	100 mg QD	20 mg	Liver
Thiamin	1.0 mg	na	50 mg QD	2.5 mg	
Vit E	15 mg	1000 mg	800 IU QD	33 IU	Liver
Vit C	75 mg	2000 mg	500 mg QD	50 mg	
B12	2.4 mcg	na	100 mcg BID	2 mcg	
Oscal	1000 mg	2500 mg	1250 mg BID	0 mg	
Mg	320 mg	350 mg	400 mg BID	0 mg	

Medications

IVIG	IG	7200 mg Q wk
Aspirin	NSAID	325 mg QD
Flovent	Antiasthma	110 mcg BID
Paxil	Antidepressant	20 mg QD +/-

Herbal Supplements

- Blue-Green Algae (Spirulina) – pt has been taking for “awhile” now
- Possibly toxic?????
- Consulted a homeopath – received new “remedies”



Labs

	Normal	Value	Date
AST	14 to 36	24	22-Jun
		48	22-Aug
		61	24-Nov
		228	27-Nov
		109	1-Dec
ALT	9 to 52	33	22-Jun
		41	22-Aug
		92	24-Nov
		279	27-Nov
		196	1-Dec

Discontinued Supplements

- Vit E – 11/30
- Niacin – 11/30
- Pyrodoxine HCL – 12/5

Labs

	Normal	Value	Date
Creatinine	0.5 - 1.5 mg/dl	0.4	8-Nov
		0.5	24-Nov
Albumin	3.2 - 5.0 g/dl	3.4	24-Nov
		3.6	1-Dec

Nutrition Diagnostic Statement

- Pt not at protein energy malnutrition risk as evident by albumin WNL and good po intake. Although pt wt decreased to 93% of admission wt this was due to muscle loss (bedridden status) and not nutritionally related.
- Pt was at micronutrient toxicity risk due to high supplementation dosage (for over a month) especially B6, niacin, and Vit E as evident by elevated liver enzymes.

Estimated Needs

- Kcal : 1650 – 1980 kcal
  - Harris Benedict
  - AF=1.1-1.2; SF=1.0-1.1
- Protein: 56 g – 70 g
  - 0.8-1.0 g/kg

Goal of Therapy

- Maintain pt's good nutritional status
- Minimize muscle wasting
- Monitor pt's supplemental use (both formulary and non-formulary)
- Establish good communication between us, pt, physicians, nurses,and any other health related professional regarding safety of supplementation.

Plan

- Assess current and future supplementation to determine toxicities or other implications
- Monitor pt’s adequate po intake and any other dietary changes that may affect the pt’s nutritional status

Potential Health Outcomes

- Reduce or Avoid toxicities of supplementation
- Avoid herbal interactions with treatments, drugs, or diet
- Keep pt in good nutritional status, minimize muscle wasting, and preserve immune function.

Potential Resources Saved

- Decrease in hospital stay and hospital resources ($)

Conclusion

- Pt diagnosis is unclear, but the bottom line is to reduce any factors that may alter pt's ability to recover. (Ie: large doses of vitamins or inadequate po intake)

Questions????